

PRINTED: 07/30/2014
FORM APPROVED

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: RC57000049	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 07/23/2014
---	---	--	---

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

FLORIDA PALMS ACADEMY

5925 MCKINLEY STREET

HOLLYWOOD, FL 33021

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 000	INITIAL COMMENTS An unannounced survey was commenced on 07/21/2014 and concluded on _____ at Florida Palms Academy Residential Treatment Center for Children and Adolescents. The facility had deficiencies at the time of the visit.	C 000		
C 034	Operating Standards - Facility Standards The facility's space and furnishings shall enable staff to respect the child's right to privacy and provide adequate supervision. Ch 65E-9.005 (5)(b)1, F.A.C. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to support the residents' privacy as evidenced by uncovered windows on all of the residents'. This has the potential to affect all 17 residents currently residing at the facility. The findings include: Observations conducted during a tour of the facility on 7/21/14 starting at 9:08 AM and ending on _____ at approximately 10:25 AM by four Agency for Health Care Administration Surveyors accompanied by the facility's Clinical Coordinator reveals that 11 of 11 residents' _____ had an uncovered square window on the door, these windows made the inside of the residents' _____ to all persons who walked in the corridor and there were no privacy curtains or covers	C 034	<u>C034 Response: Client Privacy</u> All 13 _____ will be provided with a privacy cover from the inside of the _____ a curtain no later than _____ Administrator will be responsible for monitoring and documenting the compliance of client privacy on a monthly basis.	

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

STATE FORM

KR2M11

If continuation sheet 1 of 43

PRINTED: 07/30/2014
FORM APPROVED

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: RC57000049	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/23/2014
---	---	--	---

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

FLORIDA PALMS ACADEMY

5925 MCKINLEY STREET
HOLLYWOOD, FL 33021

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 034	Continued From page 1 observed on these windows. Further observations, on _____ starting at 9:08 AM reveals that _____ #1 and #2, which were single _____ had toilets and sinks in the _____ with only a half wall and no doors, surrounding the toilet or the sink. This allowed persons passing by the _____ partially view anyone who was using either the toilets or the sink through the windows, located on the _____ m's doors. The facility's Clinical Coordinator acknowledged the findings during the tour of the facility on _____ starting at 9:08 AM and ending on _____ at approximately 10:25 AM.	C 034		
C 041	Operating Standards - Facility Standards Potable drinking water shall be readily available and easily accessible to children. Ch 65E-9.005(5)(b)8, F.A.C. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to provide drinking water that was readily available and easily accessible to the residents. This has the potential to affect all 17 residents currently residing at the facility. The findings include: Observations conducted during a tour of the facility on _____ starting at 9:08 AM and ending on _____ at approximately 10:25 AM by four Agency for Health Care Administration Surveyors accompanied by the facility's Clinical Coordinator reveals no evidence of any water fountains.	C 041	<u>C041 Response: Portable drinking water</u> A free access drinking water fountain has been installed in the main day area of the facility and outside in the play yard for clients have. Installation of both fountains were completed on _____ Administrator will be responsible for monitoring proper maintenance of the drinking fountains on monthly basis and correct any repairs immediately.	

PRINTED: 07/30/2014
FORM APPROVED

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: RC57000049	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 07/23/2014
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

FLORIDA PALMS ACADEMY

5925 MCKINLEY STREET
HOLLYWOOD, FL 33021

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 041	Continued From page 2 receptacles containing water or water coolers, in the facility's hallways, , dining area, family , any of the open living areas of the facility readily available and easily accessible to the residents. Observation, in the facility's kitchen, on , at approximately 9:30 AM reveals a large pitcher of water on the counter. During an interview on , at approximately 9:30 AM, the facility's Clinical Coordinator stated that the residents "have to ask for water."	C 041		
C 043	Operating Standards - Facility Standards shall be provided and shall be separated from halls, corridors and other by floor to ceiling walls. Children shall not have to go through another child 's get to a . Each have: a. At least one toilet, washbasin, and tub or shower easily accessible to the for each six children; b. When multiple toilets are located in a single they shall be separated by individual toilet stalls to provide individual privacy; c. with non-slip surfaces in showers or tubs; d. Toilet paper and holders, individual hand towels or disposable paper towels and soap dispensers, e. Distortion-free mirrors at a height convenient for use by children; f. A place for toiletry storage; and	C 043	C043 Response: item dispensers Toilet Paper, Paper Towel and soap dispensers for all 13 and day area ordered on and will be delivered by . Installation of these items will be no later than Administrator will be responsible for monitoring proper maintenance of the on monthly basis and correct any repairs immediately.	

PRINTED: 07/30/2014
FORM APPROVED

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: RC57000049	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER FLORIDA PALMS ACADEMY			STREET ADDRESS, CITY, STATE, ZIP CODE 5925 MCKINLEY STREET HOLLYWOOD, FL 33021		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
C 043	<p>Continued From page 3</p> <p>g. In a facility that houses children with physical _____ that limit mobility, all toilet and bathing areas shall meet the requirements of the Florida Building Code for accessibility.</p> <p>Ch 65E-9.005(5)(b)10, F.A.C.</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to provide toilet paper holders, soap dispensers and individual hand towels or disposable paper towels to the residents in their _____ or the Day _____. This affected all 17 of the facility's current residents.</p> <p>The findings include:</p> <p>Observations conducted during a tour of the facility on _____ starting at 9:08 AM and ending on _____ at approximately 10:25 AM by four Agency for Health Care Administration Surveyors accompanied by the facility's Clinical Coordinator reveals that in 11 of 11 of the residents' _____ located in the residents' _____, there was no evidence of toilet paper holders, soap dispensers and individual hand towels or disposable paper towels; the toilet paper rolls observed in each of the residents' _____ located on the vanity top, in the residents' _____.</p> <p>Observation, during the initial tour on 7/21/14 starting at 9:08 AM and ending on _____ at approximately 10:25 AM by four Agency for Health Care Administration Surveyors accompanied by the facility's Clinical Coordinator reveals that the facility has a _____ a toilet and a sink in the Day _____ that was not observed to be equipped with soap or paper towels. The Clinical Coordinator reported, during</p>	C 043			

PRINTED: 07/30/2014
FORM APPROVED

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: RC57000049	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 07/23/2014
NAME OF PROVIDER OR SUPPLIER FLORIDA PALMS ACADEMY		STREET ADDRESS, CITY, STATE, ZIP CODE 5925 MCKINLEY STREET HOLLYWOOD, FL 33021		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
C 043	Continued From page 4 the tour of the facility on _____ starting at 9:08 AM and ending on _____ at approximately 10:25 AM that the residents have a tendency to take the paper towels and soap dispensers apart. Observation on _____ at 12:16 PM reveals a resident exiting the _____ located in the Day _____ the resident went to the Nursing Station located in the Day _____ and a staff member placed some liquid soap in their hand; the staff did not provide disposable or individual towels to the resident, the resident returned to this _____ closed the door, then exited approximately one minute later. Another resident entered this _____ at 12:17 PM, then walked out of this _____ hugged a teacher, then went and sat down in the Day _____ which was occupied by residents and staff; no staff prompted the resident to wash their hands or offered soap and towels. Another resident was observed to enter this _____ at 12:19 PM and exit the _____ at 12:24 PM, the resident then went to the dining area, sat down on a chair and begun to eat their food with their hands. A staff member was in the hallway when the resident exited this _____ instructed the resident to go to the dining _____ then opened the dining _____ for the resident; the staff member did not prompt the resident to wash their hands and did not offer soap or towels to the resident. Further observations reveals another resident entered the _____ at 2:22 PM, exited several seconds later, then sat down in the Day _____ _____ was occupied by residents and staff; no staff members prompted the resident to wash his hands or offered soap and towels. In an interview, conducted on _____ at 1:30 PM with the Program Manager, the Program Manager reported that staff was expected to offer soap and paper towels to the residents who used the Day _____	C 043		

PRINTED: 07/30/2014
FORM APPROVED

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: RC57000049	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 07/23/2014
---	---	--	---

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

FLORIDA PALMS ACADEMY

5925 MCKINLEY STREET
HOLLYWOOD, FL 33021

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 043	Continued From page 5	C 043		
C 044	Operating Standards - Facility Standards a. Children shall not share sleeping areas with adolescents, and children or adolescents shall not share sleeping areas with adults. b. Separate sleeping areas shall be provided for boys and girls. c. The provider shall not permit children with physical _____ that limit mobility to sleep above the first floor. d. _____ shall have at least 50 square feet of usable floor space per resident. e. _____ with multiple occupancy shall be limited to a maximum of 4 occupants. f. _____ for children shall be separated from halls, corridors, and other _____ by floor to ceiling walls. g. Children's _____ shall be well-lighted and located convenient to a _____ shall have at least one operable exterior window. h. Each _____ be furnished with the following equipment for each child: personal storage space, such as a dresser; space for hanging clothes; a bed and mattress in good repair, which is at least 36 inches wide and 72 inches long, bedding suited to the seasons and a pillow.	C 044	C044 Response: _____ are All residents will be provided proper storage for personal belongings. Cubbies are being built into each _____ will be completed no later than _____. Administrator will be responsible for monitoring proper maintenance of the _____ on monthly basis and correct any repairs immediately.	

PRINTED: 07/30/2014
FORM APPROVED

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: RC57000049	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 07/23/2014
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

FLORIDA PALMS ACADEMY**5925 MCKINLEY STREET
HOLLYWOOD, FL 33021**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 044	<p>Continued From page 6</p> <p>i. Clean sheets, pillow cases, and blankets shall be provided for each child upon arrival. Sheets and pillowcases shall be laundered at least weekly unless greater frequency is indicated. A bedspread must be provided. Blankets or quilts must be available for use during . . . weather. Bedspreads and blankets or quilts must be laundered at least quarterly, or more often, as needed.</p> <p>j. Sleeping areas shall be assigned based on children 's individual needs for group support, privacy or independence and shall be appropriate to their ages, . . . levels and clinical needs.</p> <p>k Children shall be allowed to keep and display personal belongings and to add personal touches to the decoration of their The provider shall have and follow written procedures specifying what types of decoration are acceptable</p> <p>Ch 65E-9 005(5)(b)11, F.A.C.</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to provide a personal storage space, such as a dresser, for 17 of 17 residents currently residing in the facility and ensure that the sleeping areas for the residents were based on the residents' needs for 3 of 7 sampled residents (Resident #2, #3 and #6).</p> <p>The findings include:</p> <p>Observations, conducted during a tour of the facility on starting at 9:08 AM and ending</p>	C 044		

PRINTED: 07/30/2014
FORM APPROVED

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: RC57000049	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 07/23/2014
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

FLORIDA PALMS ACADEMY

5925 MCKINLEY STREET

HOLLYWOOD, FL 33021

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 044	<p>Continued From page 7</p> <p>on 7/21/14 at approximately 10:25 AM by four Agency for Health Care Administration Surveyors accompanied by the facility's Clinical Coordinator reveals that 11 of 11 residents' _____ had no personal storage space, such as a dresser; this affected all 17 residents who currently reside at the facility at that time. The Clinical Coordinator reported, during an interview, on _____ between 9:08 AM and _____ at approximately 10:25 AM that the facility used to have "under the bed drawers" for storage but the residents would break them and she stated that the residents' clothes were stored in a separate _____, on shelves.</p> <p>In an interview, conducted with Resident #2 on _____ at 4:49 PM, the resident reported that their clothes were kept in the separate storage _____ stated that when staff did laundry, they would mix up their clothes and stated that staff would bring the resident's bedding to the _____ the resident would, at times, sleep there when the facility was "short staffed."</p> <p>In an interview conducted on _____ at 5:12 PM with Resident #6, the resident reported that they did not like the way their clothes were stored, explained that other residents would take the resident's clothes and claim that the clothes belonged to them; stated that they noticed other residents sleeping in the _____ that this happened "usually when there is not enough staff," according to the resident, the resident slept in the _____ an unknown date at staff's request; did not know how staff had determined that the resident needed to sleep in the _____ added, "mostly all of us had that happen."</p> <p>In an interview conducted on _____ at 5:48 PM with Resident #3, the resident reported that the resident had, at times, slept in the _____</p>	C 044		

Form 3020-0001

STATE FORM

0000

KR2M11

If continuation sheet 6 of 43

PRINTED: 07/30/2014
FORM APPROVED

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: RC57000049	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 07/23/2014
NAME OF PROVIDER OR SUPPLIER FLORIDA PALMS ACADEMY		STREET ADDRESS, CITY, STATE, ZIP CODE 5925 MCKINLEY STREET HOLLYWOOD, FL 33021		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 044	Continued From page 8 and stated that they slept in the ... there was not enough staff. In an interview conducted on ... at 1:30 PM with the Program Manager, the Program Manager reported that all of the residents had individual bags for laundry and staff did each of the resident's laundry individually; explained that "some time ago" each resident used to have drawers in their ... on their beds but "it became a safety issue." The Program Manager stated, during the interview conducted on at 1:30 PM that the facility did not force the residents to sleep in the ... explained that she had no difficulties staffing the facility for the night shift, that the nurse was present each night to monitor and she monitored the facility remotely at night, through the video cameras located in the residents' sleeping and ... hallway.	C 044		
C 045	Operating Standards - Facility Standards A. ... meet the following standards: a. Be a single ... at least 50 square feet and shall be constructed to minimize the child's hiding, escape, injury or ... b. Allow staff full view of the resident in all areas of the ... outside of the ... c. Doors. 1. Doors will be made of solid-core hardwood, metal or other hard, shatter-resistant material. 2. Doors must open outward and lock using a keyless locking device that will unlock upon activation of building fire alarm and will fail safe open on loss of power to the device.	C 045	<u>C045 Response:</u> <u>Standards</u> ... & 2 door windows were replaced on ... to allow for a clear view into the & 2 had new mirrors installed which covers the entire back wall to provide a full view of the exit door wall. Installation was completed on ... Administrator will be responsible for monitoring the compliance of the ... a monthly basis to ensure full view of the ...	

PRINTED: 07/30/2014
FORM APPROVED

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: RC57000049	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ R. WING _____	(X3) DATE SURVEY COMPLETED 07/23/2014
NAME OF PROVIDER OR SUPPLIER FLORIDA PALMS ACADEMY		STREET ADDRESS, CITY, STATE, ZIP CODE 5925 MCKINLEY STREET HOLLYWOOD, FL 33021		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 045	<p>Continued From page 9</p> <p>3. The door will have no other features greater than eighteen inches from the floor to which cloth or other material may be securely hung or tied.</p> <p>d. Floors and walls.</p> <p>1. Floors and walls will be solid, smooth, and high impact resistant without metal or other</p> <p>2. Walls will lack features that are higher than eighteen inches from the floor to which cloth or other material may be securely hung or tied.</p> <p>3. Floor tiles and baseboards are acceptable if attached securely to the floor and walls.</p> <p>e. Ceilings less than nine feet above the floor shall be monolithic with no appendages that can be securely grasped or tied onto with cloth or other material.</p> <p>f. Vents less than nine feet above the floor will be covered with small wire mesh, a metal plate, or other high impact resistant material (with holes no larger than three-sixteenth inch) in such a way that one would be unable to securely tie or hang cloth or other material from it and have no exposed sharp edges.</p> <p>g. Lighting.</p> <p>1. Lighting less than nine feet above the floor will:</p> <p>a. Be recessed and covered with shatter-resistant material;</p> <p>b. Have no sharp exposed edges and lack space between it and the ceiling (or other mounting surface);</p> <p>c. Not possess features to which cloth or other material can be securely tied or hung.</p> <p>2. The lighting fixture need not be recessed if it is security-rated to withstand high impact and has a shatter-resistant cover.</p>	C 045		

PRINTED: 07/30/2014
FORM APPROVED

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: RC57000049	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 07/23/2014
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

FLORIDA PALMS ACADEMY

5925 MCKINLEY STREET
HOLLYWOOD, FL 33021

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 045	<p>Continued From page 10</p> <p>3. Material used to fill space between the fixture and the mounting surface will be hard epoxy or other material that cannot be easily removed.</p> <p>h. Mirrors and cameras. If mirrors and cameras are located in the _____ are less than nine feet above the floor, they will:</p> <ol style="list-style-type: none"> 1. Be covered with shatter-resistant material; 2. Have no sharp exposed edges and lack space between them and the ceiling (or other mounting surface); 3. Not possess features to which cloth or other material can be securely tied or hung, <p>i. Sprinklers. Sprinklers less than nine feet above the floor will:</p> <ol style="list-style-type: none"> 1. Be recessed inside a cone-shaped or other suitable housing onto which cloth or other material cannot be securely tied or hung; sprinkler systems shall be installed in accordance with National Fire Protection Association Standard 13.; 2. Lack space between the base of the housing and the surface to which it is attached; 3. Will use material to fill between the fixture and the ceiling that is hard epoxy or other material that cannot be easily removed. <p>j. Windows.</p> <ol style="list-style-type: none"> 1. Windows, when present, will be made of shatter-resistant material. 2. Any glass window that is not shatter resistant will be covered with a security-rated screen or other material that prevents access to the glass. 3. Window cranks will be flush with the window. <p>k. A toilet _____ be conveniently located near the _____ entering into or through a common use area. It shall not open</p>	C 045		

PRINTED: 07/30/2014
FORM APPROVED

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: RC57000049	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED
---	--	--	-------------------------------

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

FLORIDA PALMS ACADEMY

5925 MCKINLEY STREET
HOLLYWOOD, FL 33021

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 045	<p>Continued From page 11</p> <p>directly into or be located within the _____.</p> <p>Toilets and sinks will be smooth and devoid of handles or parts to which cloth or other material could be securely tied or hung.</p> <p>l. Smoke detectors.</p> <ol style="list-style-type: none"> 1. Smoke detectors less than nine feet above the floor will be recessed in the wall or ceiling, or enclosed in small wire mesh or other suitable material housing that prevents access to the smoke detector. 2. The wire mesh or other enclosure will have holes that are not larger than three-sixteenth inch and lack features to which cloth or other material can be securely tied or hung and shall not prevent smoke detector from properly functioning in accordance with National Fire Protection Association, 72, National Fire Alarm Code. <p>m. Electrical outlets.</p> <ol style="list-style-type: none"> 1. Electrical outlets are not permitted. 2. Electrical switches, e.g. to adjust lighting, are permissible if switches cannot be removed by the child or otherwise manipulated to gain access to the wiring. 3. Switches will not protrude so far that they permit serious self-injury. <p>n. Beds when present will:</p> <ol style="list-style-type: none"> 1. Be made of metal, heavy molded plastic, or other solid impact resistant material. 2. Be secured to the floor or wall to prevent the child from standing it upright and using it as a prop; and 3. Lack features to which cloth or other material can be securely tied, if it is higher than twenty-four inches above the floor. <p>o. Mattresses and blankets.</p>	C 045		

PRINTED: 07/30/2014
FORM APPROVED

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: RC57000049	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 07/23/2014
NAME OF PROVIDER OR SUPPLIER FLORIDA PALMS ACADEMY		STREET ADDRESS, CITY, STATE, ZIP CODE 5925 MCKINLEY STREET HOLLYWOOD, FL 33021			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
C 045	<p>Continued From page 12</p> <p>1. Each child placed in _____ will have immediate access to one plastic or vinyl-covered mattress and at least one fire retardant, triple-stitched blanket made of tear resistant material.</p> <p>2. Mattresses and blankets will be cleaned after each use, prior to being used by another child.</p> <p>p. Each _____ be inspected and certified as compliant with the above standards at least yearly and at any time damage or structural change occur.</p> <p>Ch 65E-9.005(5)(b)12, F.A.C.</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure that 2 of 2 of their _____ provided staff with a full view of their residents, in all areas inside of the _____ and #2); failed to ensure that 1 of 2 _____ was free of potentially hazardous conditions as evidenced by a metal wall plate, within reach, on the wall inside the _____ has sharp edges and multiple protruding metal screws _____ failed to ensure that the doors of 2 of 2 _____ opened outward and failed to ensure that 2 of 2 _____ were inspected and certified as compliant with the standards, at least yearly and at any time damage or structural change occurs.</p> <p>The findings include:</p> <p>Observation, on _____ at 9:40 AM by four Agency for Health Care Administration Surveyors accompanied by the facility's Clinical Coordinator reveals that the facility's two _____</p>	C 045			

PRINTED: 07/30/2014
FORM APPROVED

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: RC57000049	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/23/2014
NAME OF PROVIDER OR SUPPLIER FLORIDA PALMS ACADEMY		STREET ADDRESS, CITY, STATE, ZIP CODE 5925 MCKINLEY STREET HOLLYWOOD, FL 33021		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 045	Continued From page 13 were equipped with a window on each of the exit doors and a shielded mirror inside each of the two rooms that was expected to allow staff to be able to provide a full view of the resident inside of the ; however, when a surveyor crouched in the northwest corner, inside of ; and in the southwest corner, inside of the other surveyors and staff could not fully observe, by looking from the outside of the through the window, on the exit door and at the mirror, located inside of the what the surveyor was doing. Further observation, on /14 at 9:40 AM reveals that the window to was heavily scratched, which added to the difficulty in clearly observing the inside of The Clinical Coordinator was made aware of the observation, on at 9:40 AM, during an interview and she acknowledged the findings. Further observation, on /14 at 9:40 AM by four Agency for Health Care Administration Surveyors accompanied by the facility's Clinical Coordinator reveals a small rectangular metal plate, approximately 3 inches by 4 inches with sharp exposed edges, within reach, affixed, by multiple, protruding metal screws, to one of the walls, inside of During an interview, on at 9:40 AM, the facility's Clinical Coordinator acknowledged the observation and reported that she was not aware of the function of that metal plate. The Clinical Coordinator was asked to provide evidence that the facility inspected the during the interview, on at 9:40 AM and she stated that although the facility staff checked the , there was no evidence of documentation or a regular program for the checking of the	C 045		

PRINTED: 07/30/2014
FORM APPROVED

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: RC57000049	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 07/23/2014
---	---	--	---

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

FLORIDA PALMS ACADEMY

5925 MCKINLEY STREET
HOLLYWOOD, FL 33021

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 045	Continued From page 14 Continued observation on _____ at 9:40 AM by four Agency for Health Care Administration Surveyors accompanied by the facility's Clinical Coordinator reveals that the facility's two _____ and _____'s doors opened inward. During an interview, on _____ at 9:40 AM, the facility's Clinical Coordinator acknowledged the observations.	C 045		
C 050	Operating Stand. - Health, Sanitation, Safety The facility shall have telephones, centrally located and readily available for staff and children's use in each living unit of the facility. Emergency numbers such as the fire department, police, hospital, physician, poison control center, ambulance and Florida _____ Hotline shall be posted by each telephone. There shall be at least one cellular telephone available for use at all times in the event of power and telephone line outages. Ch 65E-9.005(6)(d), F.A.C. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure that the telephones used by the residents were readily available. The findings include: Observation on _____ between 9:13 AM and 9:40 AM by four Agency for Health Care Administration Surveyors accompanied by the	C 050	<u>C050 Response: Free access to telephone</u> A telephone will be placed in the living quarters of the residents for access to call all emergency numbers such as fire department, police, hospital, physician, poison control, ambulance and the Florida _____ Hotline no later than _____. The installer was out on _____ to provide an estimate of the phone system and proper placement of the phone. Administrator will be responsible for monitoring the compliance of having free access to a telephone.	

PRINTED: 07/30/2014
FORM APPROVED

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: RC57000049	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER FLORIDA PALMS ACADEMY			STREET ADDRESS, CITY, STATE, ZIP CODE 5925 MCKINLEY STREET HOLLYWOOD, FL 33021		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
C 050	Continued From page 15 facility's Clinical Coordinator reveals that a corded telephone, used by the residents, is located inside of the Nurses' station, out of reach of the residents. Further observation between 9:13 AM and 10:25 AM by four Agency for Health Care Administration Surveyors accompanied by the facility's Clinical Coordinator reveals no evidence of any other telephones, in the facility, readily available for the residents. Interview, with the facility's Clinical Coordinator reveals that "call out" days are Tuesday and Friday, residents can receive incoming calls, residents must ask permission to use the telephone and then the corded telephone, in the Nurses' station is handed to the resident through a "Dutch Door" outside of the Nurses' station	C 050			
C 065	Operating Standards - Transportation Safety Vehicles used to transport children shall be maintained in safe operating condition. The number of persons in a vehicle used to transport children shall not exceed the number of seats and seat belts. Seat belts shall be worn by all passengers when transporting children. Buses without seat belts are exempt from this requirement. Buses or vans used to transport children shall be equipped with a first aid kit and a non-expired fire extinguisher, rated 5BC. Ch 65E-9 005(9)(a), (b), and (c), F.A.C. This STANDARD is not met as evidenced by: Based on observation and interview, the facility	C 065	<u>C065 Response: Transportation safety</u> The Mazda vehicle had the seatbelt replaced on _____. A copy of the work order/replacement was provided to the surveyors at the exit interview. Administrator will be responsible for monitoring the compliance of the vehicle safety on a monthly basis and correct any repairs immediately.		

PRINTED: 07/30/2014
FORM APPROVED

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: RC57000049	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 07/23/2014
NAME OF PROVIDER OR SUPPLIER FLORIDA PALMS ACADEMY			STREET ADDRESS, CITY, STATE, ZIP CODE 5925 MCKINLEY STREET HOLLYWOOD, FL 33021		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
C 065	Continued From page 16 failed to ensure that 1 of 3 facility vehicles, currently used to transport the facility's residents, had safe seat belts The findings include: Observation, conducted during a tour of the facility on _____ between at 9:08 AM and 10:25 AM by four Agency for Health Care Administration Surveyors accompanied by the facility's Clinical Coordinator reveals that one of the facility's currently used vehicles, a gray Mazda, used to transport children, had a heavily frayed seat belt, located on one of the back seats, near the door of the vehicle. The Clinical Coordinator acknowledged the observation during the tour of the facility on _____ between at 9:08 AM and 10:25 AM and she stated that this was not the preferred vehicle to transport children, but reported that it was used for this purpose	C 065			
C 080	Program Standards - Food and Nutrition Food and nutrition. If the provider serves meals to staff members, they shall serve staff and children substantially the same food, except when age or special dietary requirements dictate differences. The provider shall serve three well-balanced meals a day in the morning, noon, and evening and provide snacks. If a child is admitted between meals, snacks will be provided. When children are attending school or are not present in the facility during mealtime, the provider shall make arrangements for the children's meals. The provider shall retain menus, with	C 080	<u>C080 Response: Food and Nutrition</u> A licensed dietitian has developed a weekly menu, substitution menu and disaster menu. The menus will be posted at least 24 hours prior to serving a meal, in view of the client, and will be evaluated by a licensed nutritionist for nutritional adequacy at least annually. Administrator will be responsible for monitoring the compliance of the menus on a weekly basis.		

PRINTED: 07/30/2014
FORM APPROVED

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: RC57000049	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER FLORIDA PALMS ACADEMY			STREET ADDRESS, CITY, STATE, ZIP CODE 5925 MCKINLEY STREET HOLLYWOOD, FL 33021		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
C 080	<p>Continued From page 17</p> <p>substitutions, for a 12-month period, which shall be available for review. Menus shall be posted 24 hours before serving of the meal. Any change shall be noted. Menus shall be evaluated by a consultant dietitian for nutritional adequacy at least annually. The provider shall maintain records of the dietitian's reviews.</p> <p>The provider shall plan and prepare special diets as needed (e.g., _____, bland, high calorie). No more than fourteen hours shall elapse between the end of the evening meal and the beginning of the morning meal where a protein is served. Meals shall meet general requirements for nutrition published by the department or currently found in the Recommended Daily Diet Allowances, Food and Nutrition Board, or by the Florida Dietetic Association.</p> <p>Chapter 65E-9.006(6)(a), (b), (c), and (d), F.A.C.</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to serve three well balanced meals a day; failed to post their menus 24 hours before the serving of a meal; failed to have their Nursing staff's own determined meals evaluated by a consultant dietitian for nutritional adequacy at least annually and failed to maintain the records of the dietitian's reviews.</p> <p>The findings include:</p> <p>1) Observation, in the facility's kitchen conducted during a tour of the facility on Monday, _____ between at 9:25 AM and 10:25 AM by four Agency for Health Care Administration Surveyors</p>	C 080			

PRINTED: 07/30/2014
FORM APPROVED

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: RC57000049	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 07/23/2014
NAME OF PROVIDER OR SUPPLIER FLORIDA PALMS ACADEMY		STREET ADDRESS, CITY, STATE, ZIP CODE 5925 MCKINLEY STREET HOLLYWOOD, FL 33021			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
C 080	Continued From page 18 accompanied by the facility's Clinical Coordinator reveals an <u>undated handwritten</u> menu posted on the kitchen refrigerator, documenting, in part, "Monday Breakfast- Cereal Toast, Monday Lunch- Ravioli Slice of bread; Monday Dinner- Spaghetti Meatballs Salad; Tuesday Breakfast- Cereal English Muffins; Tuesday Lunch- Corn Dogs Apple Sauce French Fries and Tuesday Dinner- BBQ (Barbeque) Wings Rice Red Kidney Beans. There was no evidence of documentation of portion size. The Program Manager stated, during an interview, on _____ at approximately 12:07 PM that the facility has a "Catering" company that bring meals to the facility and the facility heats and serves these meals and that the Nursing staff picked the menu for today. Observation, in the facility's kitchen on _____ at 1:51 PM reveals no posted menu and no evidence of a menu posted elsewhere. Observation, on Tuesday, _____ at 7:20 AM, in the facility's kitchen reveals no menu posted, sixteen Styrofoam bowls filled with cereal and covered by a napkins, on the counter in the facility's kitchen; a large empty box of corn flakes cereal and a large empty box of "Special K cereal with strawberries" in the open trash can, in the facility's kitchen and three bananas on the kitchen counter. Observation, on _____ at 7:47 AM reveals four residents in the facility's dining _____ with facility staff present, eating the cereal bowls that now contain milk along with a cup of "light yogurt." Observation, in the facility's kitchen, at 12:20 PM reveals a staff member placing one heated corn dog and approximately three spoon ladles of heated French fries on a Styrofoam plate. Observation, in the facility's dining _____ at 12:30 PM reveals six residents and facility staff with a Styrofoam plate each that contains one corn dog and approximately three	C 080			

PRINTED: 07/30/2014
FORM APPROVED

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: RC57000049	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 07/23/2014
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

FLORIDA PALMS ACADEMY**5925 MCKINLEY STREET
HOLLYWOOD, FL 33021**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 080	<p>Continued From page 19</p> <p>spoon ladles of heated French fries. Further observation, in the facility's dining , on 7/22/14 at 12:30 PM reveals the six residents being handed a plastic sealed cup containing approximately four ounces of canned fruit; opening the fruit cup and eating the contents without benefit of a spoon. Continued observation on at 12:30 PM reveals no evidence of the facility staff offering the residents a spoon. During an interview, on at 3:45 PM and review of the menu for today, the facility's Clinical Program Director stated that the fruit cup, with lunch was a dessert and that there was no fruit or vegetable for dinner today. A request was made on at 3:45 PM for the evidence of documentation of an evaluation by a consultant dietician, evidence of the review for nutritional adequacy at least annually and the maintenance the records of the dietician's reviews. During an interview on at 1:30 PM, the facility's Program Manager brought in copies of the menus provided by the catering company and stated that the catering company will be restarting today at dinner time and will be bringing meals to the facility. There was no evidence of documentation of an evaluation by a consultant dietician for the handwritten menu determined by the facility's Nursing staff and no evidence of the review for nutritional adequacy at least annually and the maintenance the records of the dietician's reviews.</p> <p>2) In an interview, conducted with Resident #2 on at 4:49 PM, the resident reported that the food at the facility was "all right, not my favorite;" reported that the facility provided the resident with enough food, but stated that they were not</p>	C 080		

PRINTED: 07/30/2014
FORM APPROVED

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: RC57000049	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ R. WING: _____	(X3) DATE SURVEY COMPLETED 07/23/2014
NAME OF PROVIDER OR SUPPLIER FLORIDA PALMS ACADEMY		STREET ADDRESS, CITY, STATE, ZIP CODE 5925 MCKINLEY STREET HOLLYWOOD, FL 33021		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 080	Continued From page 20 provided with substitutes when they did not like the served food. 3) In an interview, conducted on _____ at 5:12 PM with Resident #6, the resident reported that the food was "sometimes is good, sometimes is nasty," explained that the taste is "nasty" and staff would write in the resident's record that the resident refused food when the resident did not like the taste; stated that they could not ask for a substitute and did not get enough to eat. 4) In an interview, conducted on _____ at 5:37 PM with Resident #7, the resident reported that they did not get enough to eat; the resident reported that only sometimes there was extra food for second portions; the resident stated that they did not like the food from the catering company. 5) In an interview, conducted on _____ at 5:48 PM with Resident #5, the resident reported that the food that the facility obtained from the catering company was "horrible;" stated that the offered food was not something that they was used to eating at home. 6) In an interview, conducted on 7/22/14 at 6:22 PM with Resident #3, the resident reported that staff would eat the food that was left over; reported that they did not like the food from the catering company, explained that the food was stated that the facility did not give the resident enough to eat and the resident was still hungry after the meals; staff would inform the resident that there was no extra food, but "they lie" and the resident observed staff eating the extra food; reported that staff would not offer the resident a substitute if the resident did not like the food; stated that staff would bring in food from	C 080		

PRINTED: 07/30/2014
FORM APPROVED

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: RC57000049	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 07/23/2014
NAME OF PROVIDER OR SUPPLIER FLORIDA PALMS ACADEMY		STREET ADDRESS, CITY, STATE, ZIP CODE 5925 MCKINLEY STREET HOLLYWOOD, FL 33021		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 080	Continued From page 21 outside restaurants and taunt the residents with it.	C 080		
C 081	<p>Prog. Stand.-Health, Med, Emer Med/Psych Srvc</p> <p>Health, medical, and emergency medical and services.</p> <p>The provider shall develop and implement on an ongoing basis written procedures for health, medical, and emergency medical and services describing how the provider obtains or provides general and specialized medical, nursing, pharmaceutical and dental services.</p> <p>The procedure shall clearly specify which staff are available and authorized to provide necessary emergency or medical care, or to arrange for referral or transfer to another facility including ambulance arrangements, when necessary. The procedure shall include:</p> <ol style="list-style-type: none"> 1. Handling and reporting of emergencies. Such procedures shall be reviewed at least yearly by all staff and updated as needed; 2. Obtaining emergency diagnoses and treatment of dental problems; 3. Facilitating emergency hospitalization in a licensed medical facility; 4. Providing emergency medical and care; and 5. Notifying and obtaining consent from the parent or legal guardian in emergency situations. This procedure shall be discussed with the child's parent or guardian upon admission. The discussion shall be documented in the child's file. <p>Chapter 65E-9.006(7)(a) and (b), F.A.C.</p>	C 081	<p><u>C081 Response: Health, Medical Services</u></p> <p>Client vital signs will be taken on a monthly basis by nurses during the medication management visits with the psychiatrist. They will be recorded on a running log which will be kept with the physician's order form as well as documented on the weekly Brief Individual Mental Health and Medication Administration Note that is written by the doctor. The doctor will make comments on the Brief Individual Mental Health and Medication Administration Note as needed on any notable changes. The running log will be signed off by the doctor as well. New procedure has been implemented as of 7/28/14.</p> <p>Administrator will be responsible for monitoring the compliance of the vital signs on a monthly basis and review of the logs kept.</p>	

PRINTED: 07/30/2014
FORM APPROVED

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: RC57000049	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER FLORIDA PALMS ACADEMY			STREET ADDRESS, CITY, STATE, ZIP CODE 5925 MCKINLEY STREET HOLLYWOOD, FL 33021		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
C 081	<p>Continued From page 22</p> <p>This STANDARD is not met as evidenced by: Based on record review, and interview the facility failed to develop and implement an on-going health program to notify the resident's physician of a resident's weight loss for 5 of 7 sampled residents who had weight loss while at the facility (Resident #1, #2, #4, #5 and #7).</p> <p>The findings include:</p> <p>1) Review of Resident #1's record reveals evidence of documentation that the resident was admitted to the facility on _____ and the resident's weight on _____ was 59 pounds. Review of the "Vital Signs" log, dated 2/1/2, reveals evidence of documentation that Resident #1's weight was 61 pounds. Review of the "Vital Signs" log, dated _____ reveals of documentation that Resident #1's weight was 67 pounds. Review of the "Vital Signs" log, dated _____ reveals evidence of documentation that Resident #1's weight was 64 pounds. Review of Resident #1's "Vital Signs" log, dated _____ reveals evidence of documentation that Resident #1's weight was 62 pounds. Review of the facility's record for Resident #1 reveals no evidence of documentation or notification to the resident's physician of the resident's weight loss.</p> <p>2) Review of Resident #7's "Brief Individual Mental health and Medication Administration Notes," dated _____ reveals evidence of documentation that the resident was admitted to the facility on _____ and the resident's weight, on _____ was 144.5 pounds. Review of the "Vital Signs" log, dated _____ reveals evidence of documentation that Resident</p>	C 081			

PRINTED: 07/30/2014
FORM APPROVED

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: RC57000049	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 07/23/2014
NAME OF PROVIDER OR SUPPLIER FLORIDA PALMS ACADEMY			STREET ADDRESS, CITY, STATE, ZIP CODE 5925 MCKINLEY STREET HOLLYWOOD, FL 33021		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
C 081	Continued From page 23 #7's weight was 137 pounds. Review of the "Vital Signs" log, dated _____ reveals of documentation that Resident #7's weight was 131.5 pounds. Review of the "Vital Signs" log, dated _____ reveals evidence of documentation that Resident #7's weight was 128 pounds. Review of the "Vital Signs" log, dated _____ reveals evidence of documentation that Resident #7's weight was 122 pounds. Review of the "Vital Signs" log, dated _____ reveals evidence of documentation that Resident #7's weight was 125 pounds. Review of the facility's "Brief Individual Mental Health and Medication Administration Notes, and Medical Case Notes" for Resident #7 reveals no evidence of documentation or notification to the resident's physician of the resident's weight loss. 3) Review of Resident #5's "Brief Individual Mental Health and Medication Administration Notes," dated _____ reveals evidence of documentation that the resident was admitted to the facility on _____ and the resident's weight, on admission, was 112 pounds. Review of the "Vital Signs" log, dated _____ reveals evidence of documentation that Resident #5's weight was 108.5 pounds. Review of the "Vital Signs" log, dated _____ reveals of documentation that Resident #5's weight was 100 pounds. Review of the "Vital Signs" log, dated _____ reveals evidence of documentation that Resident #5's weight was 99.5 pounds. Review of Resident #5's "Brief Individual Mental Health and Medication Administration Notes," dated _____ reveals evidence of documentation that the resident's weight was 99.5 pounds. Review of Resident #5's "Brief Individual Mental Health and Medication Administration Notes," dated _____	C 081			

PRINTED: 07/30/2014
FORM APPROVED

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: RC57000049	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ R. WING: _____		(X3) DATE SURVEY COMPLETED 07/23/2014
NAME OF PROVIDER OR SUPPLIER FLORIDA PALMS ACADEMY			STREET ADDRESS, CITY, STATE, ZIP CODE 5925 MCKINLEY STREET HOLLYWOOD, FL 33021		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
C 081	<p>Continued From page 24</p> <p>reveals evidence of documentation that the resident's weight was 99.5 pounds. Review of the facility's Brief Individual Mental Health and Medication Administration Notes and Medical Case Notes" for Resident #5 reveals no evidence of documentation or notification to the resident's physician of the resident's weight loss.</p> <p>4) Review of Resident #2's record on _____ reveals that the resident was admitted to the facility on _____ and the resident's weight at admission was 188 pounds. Further review of the resident's record reveals evidence of documentation of the following subsequent weights; 188 pounds on 1/20/14; 158 pounds on _____ with a Psychiatrist ordered medication change, 172 pounds on 2/24/14; 173.5 pounds on _____ and 168.5 pounds on _____</p> <p>Further review of the resident's record reveals no evidence of documentation that the facility addressed the resident's weight loss. In an interview conducted with Resident #2 on _____ at 4:49 PM, the resident reported that the food at the facility was "all right, not my favorite," the resident reported that the facility provided the resident with enough food, but stated that they was not provided with substitutes when they did not like the served food. In an interview conducted on _____ at 3:45 PM with the facility's Clinical Coordinator, the Clinical Coordinator was requested to provide the facility's policy for nutritional interventions and the policy was not provided by the end of the survey. In a telephone interview conducted on _____ at 11:01 AM with the facility's Nurse Manager, the Nurse Manager reported that the facility would notify the resident's Psychiatrist if the residents were losing or gaining weight, but stated that</p>	C 081			

PRINTED: 07/30/2014
FORM APPROVED

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: RC57000049	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER FLORIDA PALMS ACADEMY			STREET ADDRESS, CITY, STATE, ZIP CODE 5925 MCKINLEY STREET HOLLYWOOD, FL 33021		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
C 081	<p>Continued From page 25</p> <p>there were no parameters of weight loss or gain for such notifications and she stated that the notifications would be documented in the resident's record. Review on _____ of the resident's record reveals no evidence of documentation that the facility made any notifications to the resident's Psychiatrist of the resident's weight loss and no evidence that the facility and or obtained a nutritional consult for the resident.</p> <p>5) Review, on 7/22/14 of Resident #4's record reveals that the resident was admitted to the facility on _____ and the resident's weight at admission was 104 pounds. Further review of the resident's record reveals evidence of documentation of the following subsequent weights; _____ - 102 pounds; 6/02/14 - 102 pounds and the Psychiatrist noted that the resident "continues to seem thinner. Will start Boost (nutritional supplement), lowered (Medication)." _____ through _____ - 102 pounds and _____ - 91 pounds. Further review of the resident's record reveals no evidence of documentation that the facility addressed the resident's continued weight loss and or obtained a nutritional consult for the resident. An interview was attempted with Resident #4 on _____ at 2:30 PM; however, the interview was not obtained due to of the resident's behaviors.</p> <p>In a telephone interview, conducted on _____ at 11:01 AM with the facility's Nurse Manager, the Nurse Manager reported that the facility would notify the resident's Psychiatrist if the residents were losing or gaining weight, but stated that there were no parameters of weight loss or gain for such notifications and she stated that the notifications would be documented in the resident's record.</p>	C 081			

PRINTED: 07/30/2014
FORM APPROVED

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: RC57000049	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 07/23/2014
NAME OF PROVIDER OR SUPPLIER FLORIDA PALMS ACADEMY		STREET ADDRESS, CITY, STATE, ZIP CODE 5925 MCKINLEY STREET HOLLYWOOD, FL 33021			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
C 084	<p>Prog. Stand.-Health, Med, Emer Med/Psych Srvc</p> <p>Health, medical, and emergency medical and services.</p> <p>The provider shall have available, either within the provider organization or by written agreement with health care providers, a full range of services for treatment of illnesses and maintenance of general health. Agreements shall include provisions for on-site visits, office visits, and hospitalization.</p> <p>Chapter 65E-9.006(7)(e), F.A.C.</p> <p>This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to have an available written agreement with a clinical dietitian. This has the potential to affect all 17 residents currently residing at the facility including five sampled residents identified with weight loss, Resident #1, #2, #4, #5 and #7. See findings for C-0081.</p> <p>The findings include:</p> <p>Review of the facility's records reveals no evidence of an available written agreement with a clinical dietitian. A request was made on _____ at 3:45 PM for the evidence of documentation of an agreement with a clinical dietitian. During an interview on 7/23/14 at 1:30 PM, the facility's Program Manager acknowledged the findings and brought in copies of the license of a clinical</p>	C 084	<p><u>C084 Response: Licensed Dietitian</u></p> <p>Copy of dietitian license was provided on _____ to the surveyors.</p> <p>Administrator will be responsible for ensuring the dietitian's license is current annually.</p>		

PRINTED: 07/30/2014
FORM APPROVED

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: RC57000049	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 07/23/2014
NAME OF PROVIDER OR SUPPLIER FLORIDA PALMS ACADEMY		STREET ADDRESS, CITY, STATE, ZIP CODE 5925 MCKINLEY STREET HOLLYWOOD, FL 33021		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 084	Continued From page 27 dietician.	C 084		
C 097	Program Standards - Child's record The provider shall develop an individualized record for each child. The form and detail of the records may vary but shall, at a minimum, include: 1. Identification and contact information, including the child's name, date of birth, Social Security number, gender, race, school and grade, date of admission, and the parent or guardian's name, address, home and work telephone numbers; 2. Source of referral; 3. Reason for referral to residential treatment, e.g., chief complaint, presenting problem(s); 4. Record of the complete assessment; 5. DSM diagnosis; 6. Treatment plan; 7. Medication history; 8. Record of medication administered by program staff, including type of medication, dosages, frequency of administration, persons who administered each dose, and method of administration; 9. Documentation of course of treatment and all evaluations and examinations, including those from other facilities, such as emergency or general hospitals; 10. Progress notes; 11. Treatment summaries; 12. Consultation reports; 13. Informed consent forms; 14. A chronological listing of previous placements, including the dates of admission and discharge, and dependency and delinquency actions affecting the minor's legal status; 15. Written individual education plan for the child, when applicable;	C 097	<u>C097 Response: Client Vitals</u> Client vital signs will be taken on a monthly basis by nurses during the medication management visits with the psychiatrist. They will be recorded on a running log which will be kept with the physician's order form as well as documented on the weekly Brief Individual Psychotherapy Mental Health and Medication Administration Note that is written by the doctor. The doctor will make comments on the Brief Individual Mental Health and Medication Administration Note as needed on any notable changes. The running log will be signed off by the doctor as well. New procedure has been implemented as of Administrator will be responsible for monitoring the compliance of the vital signs on a monthly basis and review of the logs kept.	

PRINTED: 07/30/2014
FORM APPROVED

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: RCS7000049	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/23/2014
NAME OF PROVIDER OR SUPPLIER FLORIDA PALMS ACADEMY		STREET ADDRESS, CITY, STATE, ZIP CODE 5925 MCKINLEY STREET HOLLYWOOD, FL 33021			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
C 097	<p>Continued From page 28</p> <p>16. The discharge summary, which shall include the initial diagnosis, clinical summary, treatment outcomes, assessment of child's treatment needs at discharge, the name, address and phone number of person to whom the child was discharged and follow-up plans. In the event of a summary shall be added to the record and shall include circumstances leading to the</p> <p>All discharge summaries shall be signed by the clinical or medical director;</p> <p>17. For out of state children, copies of completed interstate compact ICPC 100A and ICPC 100B forms (2002) and a copy of each Interstate Compact Transmittal Memorandum and any attachments thereto that were sent to the Residential Treatment Center by the department's Interstate Compact on the Placement of Children Office;</p> <p>18. Documentation of any use of _____ or time out;</p> <p>19. A copy of each incident report that includes a clear description of each incident; the time, place, and names of individuals involved; witnesses; nature of injuries, if any; cause, if known; action(s) taken; a description of medical services provided, if any; by whom such services were provided, and any steps taken to prevent a recurrence. Incident reports shall be completed by the individual having first hand knowledge of the incident, including paid and volunteer staff, emergency or temporary staff, and student interns; and</p> <p>20. Documentation that all of the various notices and copies required by these rules were properly given.</p> <p>Records of discharged children shall be completed within 15 business days following</p>	C 097			

PRINTED: 07/30/2014
FORM APPROVED

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: RC57000049	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 07/23/2014
NAME OF PROVIDER OR SUPPLIER FLORIDA PALMS ACADEMY		STREET ADDRESS, CITY, STATE, ZIP CODE 5925 MCKINLEY STREET HOLLYWOOD, FL 33021			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
C 007	<p>Continued From page 29</p> <p>discharge.</p> <p>Chapter 65E-9.006(12)(b) and (c), F.A.C.</p> <p>This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to maintain a complete and accurate record for 5 of 7 sampled residents (Resident #1, #2, #4, #5 and #7).</p> <p>The findings include:</p> <p>1) Review of Resident #1's record reveals evidence of documentation that the resident was admitted to the facility on _____ and the resident's weight on _____ was 59 pounds. Review of the "Vital Signs" log, dated 2/1/2 reveals evidence of documentation that Resident #1's weight was 61 pounds. Review of the "Vital Signs" log, dated _____ reveals of documentation that Resident #1's weight was 67 pounds. Review of the "Vital Signs" log, dated _____ reveals evidence of documentation that Resident #1's weight was 64 pounds. Review of Resident #1's "Vital Signs" log, dated _____ reveals evidence of documentation that Resident #1's weight was 62 pounds. Review of the facility's record for Resident #1 reveals no evidence of documentation or notification to the resident's physician of the resident's weight loss.</p> <p>2) Review of Resident #7's "Brief Individual Mental health and Medication Administration Notes," dated _____ reveals evidence of documentation that the resident was admitted to the facility on _____ and the resident's weight, on _____ was 144.5 pounds.</p>	C 007			

PRINTED: 07/30/2014
FORM APPROVED

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: RCS7000049	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 07/23/2014
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

FLORIDA PALMS ACADEMY**5925 MCKINLEY STREET
HOLLYWOOD, FL 33021**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) LETE ... JC
C 097	<p>Continued From page 30</p> <p>Review of the "Vital Signs" log, dated _____ reveals evidence of documentation that Resident #7's weight was 137 pounds. Review of the "Vital Signs" log, dated _____ reveals of documentation that Resident #7's weight was 131.5 pounds. Review of the "Vital Signs" log, dated 3/23/14 reveals evidence of documentation that Resident #7's weight was 128 pounds. Review of the "Vital Signs" log, dated _____ reveals evidence of documentation that Resident #7's weight was 122 pounds. Review of the "Vital Signs" log, dated _____ reveals evidence of documentation that Resident #7's weight was 125 pounds. Review of the facility's "Brief Individual Mental Health and Medication Administration Notes, and Medical Case Notes" for Resident #7 reveals no evidence of documentation or notification to the resident's physician of the resident's weight loss. Review of the "Brief Individual Mental Health and Medication Administration Notes" included the resident's vital signs and the resident had the following documented vital signs: On _____ 112/76, Pulse 102, Temperature 97.3, Weight 144.5 pounds and height 66 inches; On _____ resident had the same documented vital signs. On _____ and _____ there were no vital signs documented; On _____ BP _____ Pulse 100, Temperature 99.0, Weight 137 pounds and height 65 inches a loss of 1 inch since _____; On _____ the resident had the same documented vital signs; On _____ there was no evidence of a measurement recorded, Pulse 96, Temperature 99.0, Weight 128 pounds and Height 66 inches, a gain of 1 inch since _____; On _____ 5/29/14, _____ and _____ the resident had the same documented vital signs. Review of</p>	C 097		

PRINTED: 07/30/2014
FORM APPROVED

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: RC57000049	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 07/23/2014
NAME OF PROVIDER OR SUPPLIER FLORIDA PALMS ACADEMY		STREET ADDRESS, CITY, STATE, ZIP CODE 5925 MCKINLEY STREET HOLLYWOOD, FL 33021			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
C 097	Continued From page 31 the facility's record for Resident #7 reveals no evidence of documentation or notification to the resident's physician of the discrepancy between the documentation on the resident's "Vital Signs" log and the resident's "Brief Individual Mental Health and Medication Administration Notes." 3) Review of the "Vital Signs" log, dated ... reveals that Resident #5's weight was 99.5 pounds. Pulse 100, Temperature: 97.2 and Height: 60 and 1/2 inches. Review of Resident #5's "Brief Individual Mental Health and Medication Administration Notes," dated ... reveals that the resident's weight was 99.5 pounds BP ... Pulse 100, Temperature: 97.2 and Height: 5 Feet (60 inches). This height documented that the resident was a 1/2 inch shorter than measured on ... Review of Resident #5's "Brief Individual Mental Health and Medication Administration Notes," dated ... reveals the same vital signs as on the "Brief Individual Mental Health and Medication Administration Notes," dated ... 4) Review of Resident #2's record on revealed that the resident was admitted to the facility on 1/08/14 and the record reveals that the	C 097			

PRINTED: 07/30/2014
FORM APPROVED

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: RC57000049	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER FLORIDA PALMS ACADEMY			STREET ADDRESS, CITY, STATE, ZIP CODE 5925 MCKINLEY STREET HOLLYWOOD, FL 33021		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
C 097	Continued From page 32 resident received weekly _____ and medical administration reviews from the Psychiatrist. The "Brief Individual Mental Health and Medication Administration Notes" included the resident's vital signs and the resident had the following documented vital signs: On _____, Pulse _____ 92; Temperature 97.4 degrees; Weight 188 pounds and Height 64 inches; On _____, the same vital signs were documented; _____, Pulse 92; Temperature 97.4 degrees; Weight 188 pounds and Height 64 inches; On _____, Pulse 68, Temperature 97.8, Weight 158 _____ and Height 61 and 1/4 inches; this height documented that the resident was shorter than initially measured. On _____ there were no vitals documented; On _____ there were no vital signs documented; On 2/24/14, _____ Pulse 72, Temperature 97.2, Weight 172 pounds and Height was 63 inches; the height documented that the resident grew two inches; h) On _____ there were no vitals documented, but the resident was in the facility; On _____ there were no vital signs documented; On _____ was _____ Pulse was 99, Temperature was 97.8, Weight was 173.5 pounds, Height was 62 and 1/2 inches; the height documented that the resident was shorter than the previous measurement. On _____ and _____ the resident had the same documented vital signs, including the same _____ and Pulse; On _____ 126/70, Pulse 95, Temperature 97.6 degrees, Weight was 168.5 _____, Height was 62 and 1/4 inches; On _____ 7/04/14, and _____ the resident had the same documented vitals, including the same _____ and Pulse. In a telephone interview, conducted on _____ at 11:01 AM with the Nurse Manager, the Nurse Manager reported that a nurse was	C 097			

PRINTED: 07/30/2014
FORM APPROVED

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: RC57000049	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/23/2014
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

FLORIDA PALMS ACADEMY

5925 MCKINLEY STREET
HOLLYWOOD, FL 33021

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 097	<p>Continued From page 33</p> <p>responsible for obtaining the vital signs assessments once a month and the nurses were expected to notify the Psychiatrist if there were any abnormal findings. In an interview, conducted on _____ at approximately 11:15 AM with the Clinical Coordinator, the Clinical Coordinator was made aware of the lack of accurate documentation of the vital signs and she acknowledged the findings.</p> <p>5) Review on _____ of Resident #4's record reveals that the resident was admitted to the facility on _____ and the record reveals that the resident received weekly _____ Medical and Medication Administration reviews from the Psychiatrist. The "Brief Individual Mental Health and Medication Administration Notes" included the resident's vital signs and the resident had the following documented vital signs: on _____, there are no documented vital signs; On _____, _____ was _____, Pulse was 88, Temperature was 98.6, Weight was 104 pounds and Height was 58 inches; On _____ there were no documented vital signs; On _____, Pulse 115, Temperature 98.7, Weight 102 and Height was 56 and 3/4 inches; the height documented that the resident was shorter than the previous measured height. On _____ and _____, the resident had the same documented vital signs; On _____ and _____, Pulse 91, Weight was 91 pounds and height was 58 inches; the height documented a growth of 1.25 inches from the previous measurement. In an interview conducted on _____ at approximately 11:15 AM with the Clinical Coordinator, the Clinical Coordinator was made aware of the lack of accurate documentation of</p>	C 097		

PRINTED: 07/30/2014
FORM APPROVED

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: RC57000049	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER FLORIDA PALMS ACADEMY			STREET ADDRESS, CITY, STATE, ZIP CODE 5925 MCKINLEY STREET HOLLYWOOD, FL 33021		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
C 097	Continued From page 34 the vital signs and she acknowledged the findings.	C 097			
C 183	Rights of Children - Child & neglect Each child shall have ready access to a telephone in order to report an alleged neglect or The provider shall inform each child verbally and in writing of the procedure for reporting A written copy of that procedure, including the telephone number of the hotline and reporting forms, shall be posted in plain view within eighteen inches of the telephone(s) designated for use by the children. Chapter 65E-9.012(3)(b), F.A.C. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to post a written copy of the procedure for reporting including the telephone number of the Hotline and reporting forms, in plain view within eighteen inches of the telephone designated for use by the residents. The findings include: Observation on between 9:13 AM and 9:40 AM by four Agency for Health Care Administration Surveyors accompanied by the facility's Clinical Coordinator reveals that a corded telephone, used by the residents, is located inside of the Nurses' station, out of reach of the residents. Further observation between 9:13 AM and 10:25 AM by four Agency for Health Care Administration Surveyors accompanied by the facility's Clinical Coordinator reveals no evidence	C 183	<u>C183 Response: Reporting Procedure</u> A telephone will be placed in the living quarters of the residents for access to call all emergency numbers such as fire department, police, hospital, physician, poison control, ambulance and the Florida Hotline. Procedures to call the hotline will be posted within 18 inches of the newly installed telephone no later than 8/22 Administrator will be responsible for ensuring the telephone is in working order at all times and make repairs immediately if it is not.		

PRINTED: 07/30/2014
FORM APPROVED

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: RC57000049	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 07/23/2014
---	---	--	---

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

FLORIDA PALMS ACADEMY

5925 MCKINLEY STREET
HOLLYWOOD, FL 33021

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 183	Continued From page 35 of any other telephones, in the facility, readily available for the residents. Interview, with the facility's Clinical Coordinator reveals that residents must ask permission to use the telephone and then the corded telephone, approximately 36 inches from the resident, in the Nurses' station, is handed to the resident through a "Dutch Door" outside of the Nurses' station. Further observation, conducted during a tour of the facility on _____ between at 9:08 AM and 10:25 AM by four Agency for Health Care Administration Surveyors accompanied by the facility's Clinical Coordinator reveals that the written copy of the procedure for reporting including the telephone number of the Hotline and reporting forms are posted on the Nurses' Station window, approximately 36 inches from the telephone when used by the residents. The facility's Program Manager acknowledged the findings during an interview on _____ at approximately 1:30 PM.	C 183		
C 207	_____ -- Authorization If a child requires the use of _____ or _____ at any time during their stay, the treatment team shall formally review and actively address their use during the child's regularly scheduled treatment team review meetings, no less frequently than two times per month, until deemed no longer necessary. The reviews shall assess the frequency, patterns and trends, and identify ways to prevent the need for _____ and _____ use. The treatment team's review of _____ and efforts to eliminate _____ and _____ use with a specific child shall be documented as part of the child's treatment team review. In addition, if a child is restrained a total of two times within a thirty day period, or is in _____	C 207	C207 Response: <u>Time Out Authorization</u> The use of _____ and _____ will be reviewed no less than 2 times a month with the resident's treatment team. This will assess the frequency, patterns and trends and identify ways to prevent the need for seclusion and _____ use. New process will be implemented as of 8/15/14. Administrator will be responsible for monitoring the compliance of the _____ and _____ bi-weekly review on a monthly basis by the QA/QI team.	

PRINTED: 07/30/2014
FORM APPROVED

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: RC57000049	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 07/23/2014
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

FLORIDA PALMS ACADEMY

5925 MCKINLEY STREET
HOLLYWOOD, FL 33021

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 207	<p>Continued From page 36</p> <p>a total of three times within a thirty day period, the treatment team will oversee the development and monitor the implementation of a formal child-specific plan to aggressively address the need for _____ and _____ use with that child.</p> <p>Chapter 65E-9.013(3)(h), F.A.C.</p> <p>This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure that the treatment team formally review and actively address the use of _____ or _____ during the scheduled treatment team meetings, no less than two times per month for a resident requiring the use of _____ or _____ for 1 of 7 sampled resident's records reviewed (Resident #3).</p> <p>The findings include: Review of the facility's own _____ and _____ "Tracking Log" reveals evidence of documentation that Resident #3 was restrained on 5/17/14 and on _____. Review of the facility's own "Monthly Treatment Plan and Progress Summary," dated _____ for the month of _____ 2014 reveals evidence of documentation of the use of _____ on 5/17/14 and _____ for Resident #3. Further review of Resident #3's record failed to reveal any other evidence of documentation that the _____ was reviewed or addressed a second time in the month as required. In an interview conducted on _____ at 3:10 PM with the facility's Clinical Director, she confirmed that there is no evidence of documentation of a second review of the _____ for Resident #3.</p>	C 207		

PRINTED: 07/30/2014
FORM APPROVED

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: RC57000049	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 07/23/2014
NAME OF PROVIDER OR SUPPLIER FLORIDA PALMS ACADEMY		STREET ADDRESS, CITY, STATE, ZIP CODE 5925 MCKINLEY STREET HOLLYWOOD, FL 33021		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 217	Continued From page 37	C 217	<u>C217 Response: Post Intervention Debriefings</u>	
C 217	<p>After the use of _____ or _____ staff involved in an emergency safety intervention and the child shall have a face-to-face discussion, which is also known as a debriefing. Whenever possible, subject to staff scheduling, this discussion shall include all staff involved in the intervention. The child's parent or guardian shall be invited to participate in the discussion. The provider shall conduct the discussion in a language that is understood by the child and the child's parent or guardian. The discussion shall provide both the child and staff the opportunity to discuss the circumstances resulting in the use of _____ or _____ and strategies to be used by the staff, the child, or others to prevent the need for the future use of _____ or _____. The discussion must occur within 24 hours of the emergency intervention, subject to the following exceptions:</p> <ol style="list-style-type: none"> 1. Allowances may be made to accommodate the schedules of the parent(s) or legal guardian(s) of the child when they request an opportunity to participate in the debriefing and when staff deem their participation appropriate. 2. Allowances may be made to accommodate shift changes, vacation schedules, illnesses, and all applicable federal, state, and local labor laws and regulations. <p>Chapter 65E-9.013(10)(a), F.A.C.</p> <p>This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure that a face to face discussion with all staff and the resident involved in an</p>	C 217	<p>All face-to-face debriefings with the client will occur within 24 hours of the _____ or _____.</p> <p>All face-to-face debriefings with the staff involved will occur in 24 hours of the _____ or _____.</p> <p>If a staff member is not able to participate, explanation of non-participation will be documented on the debriefing.</p> <p>Administrator will be responsible for monitoring the compliance of the post intervention debriefings on a monthly basis by the QA/QI team.</p> <p>Implementation of changes have begun as of _____.</p>	

PRINTED: 07/30/2014
FORM APPROVED

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: RC57000049	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 07/23/2014
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

FLORIDA PALMS ACADEMY

5925 MCKINLEY STREET
HOLLYWOOD, FL 33021

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 217	<p>Continued From page 38</p> <p>emergency safety intervention was conducted for 1 of 7 sampled resident's records reviewed (Resident #3).</p> <p>The findings include:</p> <p>Review of the facility's own _____ and _____ Tracking Log" reveals that Resident #3 was restrained on _____ beginning at 7:35 PM and ending at 7:50 PM and the staff members initiating the _____ were Staff #C and Staff #G. Review of the facility's own "IESCAPE Interview form" reveals evidence of documentation that the debriefing face to face discussion with Resident #3 was conducted on _____ from 9:11 PM to 9:25 PM; Staff #C was not present; there was no evidence of documentation of an explanation of Staff #C's absence and further review reveals that the discussion occurred more than 24 hours after the emergency safety intervention. Review of the facility's own _____ and _____ Tracking Log" reveals that Resident #3 was restrained on _____ beginning at 10:33 AM and ending at 10:34 AM; was in _____ on _____ beginning at 10:34 AM and ending at 10:54 AM and the staff members initiating the _____ were Staff #D and Staff #H. Review of the facility's "IESCAPE Interview form" reveals that the debriefing face to face discussion with Resident #3 was conducted on _____ from 11:20 AM to 11:40 AM; Staff #D was not present and there was no evidence of documentation of an explanation documented regarding the staff member's absence. In an interview conducted on _____ at 1:31 PM with the Program Manager, she reviewed the resident's record and confirmed the findings.</p>	C 217		

PRINTED: 07/30/2014
FORM APPROVED

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: RC57000049	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER FLORIDA PALMS ACADEMY		STREET ADDRESS, CITY, STATE, ZIP CODE 5925 MCKINLEY STREET HOLLYWOOD, FL 33021		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 218 C 218	Continued From page 39 After the use of _____ or _____ the staff involved in the emergency safety intervention, and appropriate supervisory and administrative staff, shall conduct a debriefing session that includes a review and discussion of: 1. The emergency safety situation that required the intervention, including a discussion of the factors that caused or preceded the intervention; 2. Alternative, less intrusive techniques that might have prevented the need for the _____ or _____ 3. The procedures, if any, that staff are to implement in the future to prevent any recurrence of the use of _____ or _____ and 4. The outcome of the intervention, including any injuries that resulted from the use of _____ or _____ and the treatment provided for those injuries. Chapter 65E-9.013(10)(b), F.A.C. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure that all staff involved in an emergency safety intervention were present at the required debriefing session conducted after the use of _____ or _____ for 1 of 7 sampled resident's records reviewed (Resident #3). The findings include:	C 218 C 218	<u>C218 Response: Post Intervention Debriefings</u> All face-to-face debriefings with the staff involved will occur in 24 hours of the _____ or _____ If a staff member is not able to participate, explanation of non-participation will be documented on the debriefing. Administrator will be responsible for monitoring the compliance of the post intervention debriefings on a monthly basis by the QA/QI team. Implementation of changes have begun as of 7/28/14.	

PRINTED: 07/30/2014
FORM APPROVED

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: RCS7000049	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
---	--	--	-------------------------------

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

FLORIDA PALMS ACADEMY

5925 MCKINLEY STREET
HOLLYWOOD, FL 33021

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE PRECEDED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 218	<p>Continued From page 40</p> <p>Review of the facility's own _____ and _____ Tracking Log" reveals evidence of documentation that Resident #3 was restrained on _____ beginning at 7:35 PM and ending at 7:50 PM and the staff members initiating the _____ were Staff #C and Staff #G.</p> <p>Review of the facility's own "Post _____ Staff Debriefing form" reveals evidence of documentation that the debriefing session discussion for Resident #3 was conducted on _____ at 10:20 AM. Staff #C was not present and there was no evidence of documentation of an explanation for the absence.</p> <p>Review of the facility's own _____ and _____ Tracking Log" reveals evidence of documentation that Resident #3 was restrained on _____ beginning at 10:33 AM and ending at 10:34 AM; was in _____ on _____ beginning at 10:34 AM and ending at 10:54 AM and the staff members initiating the _____ were Staff #D and Staff #H.</p> <p>Review of the facility's own "Post _____ Staff Debriefing form" reveals evidence of documentation that the debriefing session discussion for Resident #3 was conducted on _____ at 2:30 PM. Staff #D was not present and there was no evidence of documentation of an explanation for the absence.</p> <p>Review of the facility's own _____ and _____ Tracking Log" reveals evidence of documentation that Resident #3 was restrained on _____ beginning at 10:04 PM and ending at 10:06 PM, was in _____ on _____ beginning at 10:06 PM and ending at 10:33 PM and the staff members initiating the _____ were Staff #E and Staff #F.</p> <p>Review of the facility's own "Post _____ Staff Debriefing form" reveals evidence of documentation that the debriefing session discussion for Resident #3 was</p>	C 218		

PRINTED: 07/30/2014
FORM APPROVED

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: RC57000049	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 07/23/2014
NAME OF PROVIDER OR SUPPLIER FLORIDA PALMS ACADEMY			STREET ADDRESS, CITY, STATE, ZIP CODE 5925 MCKINLEY STREET HOLLYWOOD, FL 33021		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
C 218	Continued From page 41 conducted on _____ at 11:20 AM; Staff #E and Staff #F were not present and there was no evidence of documentation of an explanation for the absence. In an interview, conducted on 7/23/14 at 1:31 PM with the Program Manager, she reviewed the resident's record and confirmed the findings.	C 218			
C 235	Time-out The child's treatment team shall review the use of time-out during that child's treatment team meetings, but no less frequently than two times per month. This review shall consist of assessing the frequency, patterns and trends, questioning the function(s) of the behavior(s) that resulted in the use of time-out, possible ways to prevent the behaviors(s) and the appropriateness of the exit criteria used. Chapter 65E-9.013(11)(I), F.A.C. This STANDARD is not met as evidenced by: Based on Record Review and interview, the facility failed to review the use of time-out during that resident's treatment team meetings, no less frequently than two times per month, consisting of assessing the frequency, patterns and trends, questioning the function of the behavior that resulted in the use of time-out, possible ways to prevent the behaviors and the appropriateness of the exit criteria used for 2 of 7 sampled residents (Resident #4 and #5). The findings include: 1) Review of Resident #4's record on _____	C 235	<u>C235Response:</u> <u>Time Out Authorization</u> The use of Time Outs are currently being reviewed no less than 2 times a month with the resident's treatment team. This will assess the frequency, patterns and trends and identify ways to prevent the need for _____ and _____ use. New procedure will be implemented as of 8/15/14. Time outs will also be addressed on the Monthly Treatment Plan and Progress Summary. Administrator will be responsible for monitoring the compliance of the Time Out bi-weekly review on a monthly basis by the QA/QI team.		

PRINTED: 07/30/2014
FORM APPROVED

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: RC57000049	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 07/23/2014
---	---	--	---

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

FLORIDA PALMS ACADEMY

5925 MCKINLEY STREET
HOLLYWOOD, FL 33021

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 235	<p>Continued From page 42</p> <p>reveals that resident was admitted to the facility on _____ and the resident had a time out on _____. Further review of the resident's record reveals no evidence of documentation that the resident's treatment team reviewed the use of the time-out no less than two times per month. In an interview, conducted on _____ at 3:14 PM with the facility's Clinical Coordinator, the Clinical Coordinator acknowledged that the resident had a time out, but stated that the treatment team would address time outs only if the resident had a high frequency of time outs.</p> <p>2) Review of the facility's Time Out case notes revealed that Resident # 5 was on time out on _____ and on _____. Review of the "Monthly Treatment Plan and Progress Summary," dated _____ for the month of _____ 2014 reveals evidence of documentation of _____ one with no date, duration or reason documented. Further review of Resident #5's record failed to reveal any other evidence of documentation that the time out was reviewed or addressed by the treatment team a second time in the month as required. Review of the "Monthly Treatment Plan and Progress Summary," dated _____ for the month of _____ 2014 reveals no evidence of documentation of the time out that occurred on _____. Further review of Resident #5's record failed to reveal any other evidence of documentation that the time out was reviewed or addressed by the treatment team at any time during the month as required. In an interview, conducted on _____ at 1:04 PM with the facility's Clinical Director, she confirmed that there is no evidence of documentation of a second review of the time out on _____ for Resident #5 or any other evidence of documentation of the time out on _____.</p>	C 235		



RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

FED-EX OVERNIGHT 8047 3836 2934
SIGNATURE REQUIRED

2014

Administrator
Florida Palms Academy
5925 McKinley Street
Hollywood, FL 33021

Dear Administrator:

This letter reports the findings of a survey that was commenced on _____, 2014 and concluded on _____, 2014 by representatives of this office.

Attached is the provider's copy of the State (3020) Form, which indicates the deficiencies that were identified on the days of the visit.

Please provide a plan of correction to this Field Office, in accordance with enclosed instructions, for the identified deficiencies **within ten working days of receipt of this report**. **All deficiencies shall be corrected no later than _____, 2014.**

The plan of correction must include the following:

1. Identify how corrective action will be accomplished for those residents found to have been affected by the deficient practice.
2. Describe how the facility will identify other residents having the potential to be affected by the same deficient practice.
3. Explain measures to be put into place or systemic changes made to ensure that the deficient practice will not recur.
4. Identify how the facility will monitor its corrective action to ensure the deficient practice is being corrected and will not recur; i.e., what program will be put into place to monitor the continued effectiveness of the systemic change.
5. Ensure that no protected or other confidential information (i.e., resident or staff names) are included in the plan.
6. State the completed date; the date that the facility identifies compliance can be achieved, which must be after the exit date.
7. You must sign the bottom of page 1 of the statement of deficiencies; include your title and date.

The Quality Assurance Questionnaire has long been employed to obtain your feedback

Delray Beach Field Office
5150 Linton Boulevard, Suite 500
Delray Beach, FL 33484
Phone: (561) 381-5840; Fax: (561) 496-5924
AHCA.MyFlorida.com

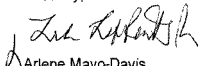


Facebook.com/AHCAFlorida
Youtube.com/AHCAFlorida
Twitter.com/AHCA_FL
SlideShare.net/AHCAFlorida

following survey activity. This form has been placed on the Agency's website at <http://ahca.myflorida.com/Publications/Forms.shtml> as a first step in providing a web-based interactive consumer satisfaction survey system. You may access the questionnaire through the link under Health Facilities and Providers on this page. Your feedback is encouraged and valued, as our goal is to ensure the professional and consistent application of the survey process.

Thank you for the assistance provided to the representatives. Should you have any questions please call this office at (561) 381-5840.

Sincerely,


Arlene Mayo-Davis
Field Office Manager

AMD

Enclosure:State Form 3020

TBB2